Maternal-Infant Health Program Design Workgroup Notes

February 17, 2005

Present: Bonnie Ayers, Dianna Baker, Mark Bertler, Anne Bianchi, Lynette Biery, Sandra Brandt, Suzette Burkitt-Wesolek, Alethia Carr, Paulette Dobynes Dunbar, Sheila Embry, Brenda Fink, Sue Gough, Mary Ludtke, Deb Marciniak, Phyllis Meadows, Sara Paas (for Judy Fitzgerald), Doug Paterson, Jackie Prokop, Diane Revitte, Paul Shaheen, Betty Tableman, Peggy Vander Meulen, Darlene VanOveren (for Rick Haverkate), Betty Yancey.

Present via phone: Dianne Douglas, Pat Fralick, Nancy Heyns, Mary Pat Randall, Carolynn Rowland, Sharon Wallace.

Not present: Ingrid Davis, Stacey Duncan-Jackson, Sheri Falvay, Judy Fitzgerald, Adnan Hammad, Rick Haverkate, Ed Kemp, Sue Moran, Rick Murdock, Tom Summerfelt.

Future MIHP Design Workgroup Meeting Dates

~~Thurs., March 17, 2005~~	CANCELED
Wed., April 13, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Thurs., May 19, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Thurs., June 16, 2005	1:00 – 3: 30 pm MPHI Interactive Learning Center
Thurs., July 14, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Thurs., Aug 18, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Thurs., Sept. 8, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Tues., Oct. 4, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center
Tues., Nov. 8, 2005	1:00 – 3:00 pm MPHI Interactive Learning Center
Tues., Dec. 6, 2005	1:00 – 3:30 pm MPHI Interactive Learning Center

Tasks / Assignments

1. Lynette Biery will look into adding this question to the list of reactivity questions: "Would you have answered the questions more honestly if you had done the screener by yourself, instead of being interviewed by another person?"
2. DWG members will email their input on the *Maternal Screening Tool* and the *Maternal Risks, Interventions, and Outcomes Matrix* to Lynette Biery at Lynette.Biery@hc.msu.edu. Ideally, comments will include recommendations and supportive documentation.
3. Lynette Biery will present the DWG's comments on the *Maternal Screening Tool* to the research team after the pilot testing is completed, when the team is in the process of revising the screener based on what was learned from the pilot.

Review of MIHP Maternal Screening Tool

Lynette Biery, Project Manager, Institute for Health Care Studies, MSU, did a PowerPoint presentation on the *MIHP Prenatal Risk Factor Screening Tool.* The presentation covered screening tool development, pilot testing, screening domains, review of the tool, and where we go from here. Doug noted that the tool is being

developed as part of a research project that the IHCS began before the MIHP re-design effort was initiated.

Development of the screening tool is driven by the literature, with input provided by OB-GYNS, pediatricians, family practitioners, psychologists, etc. from the pilot sites and MSU. Most of the questions have been validated in the literature.

Each of the 3 pilot sites will work with WIC to test a different screening tool format: Kent – electronic tablet; Genesee – paper; District 10 – PDA. The amount of time it takes to conduct the screening will be tracked at all 3 sites (this is done automatically for the sites that are piloting electronic formats). Self-administration of the screening tool by pregnant women is not being tested at this time.

Experienced paraprofessional community health workers (CHWs) will be conducting the screenings in Genesee; WIC staff in Kent; and MSS nurses in District 10. Training will be provided for all. Kent is integrating the WIC and MIHP screeners, identifying the common questions so women won't have to answer them twice.

The goal is to test the screener with 100 women at each site (many more than 100 will be recruited to allow for drop-out). A convenience sample will be used (whoever walks through the door). IHCS expects to get a significant sample of African Americans, but not significant samples of Native Americans, Arabs - Chaldeans, or Hispanics. Doug said this would be addressed later.

The screener is a lot to digest. It covers basics/demographics, health history/risks, prenatal care, smoking, alcohol, drug use, stress, depression, social support, abuse/violence, basic needs and breastfeeding. A black arrow means go to the next question or response category in the direction of the arrow. A white arrow means skip to the indicated question or response category. A SNAG box is provided so that interviewers can note any "snags/problems" with a given question. Questions for which snags are repeatedly noted, will be re-worked or deleted. The screener works great electronically.

For many items there are Tier 1 (general) and Tier 2 (more in-depth) questions. How the woman answers a Tier 1 question determines whether or not the interviewer moves on to the Tier 2 questions. For example, if a woman answers the Tier 1 smoking question affirmatively, she is then asked a series of questions taken from the literature on level of nicotine addiction (4.3 series) and readiness to change (4.4 series).

ICHS has moved away from distinguishing between screening and assessment. For example, they incorporated the 4-question screener recommended by the Public Health Service as the Tier 1 questions on depression. (The PHS has 2, 4, 10, and 14-question screeners.) If a woman screens positively on those four questions, the interviewer immediately administers the Tier 2 questions – the Edinburgh Postpartum Depression Scale. Technically, the Edinburgh is a screener, but it is much more in-depth than the Tier 1 questions.

Questions/comments were raised about the following items on the screener:

1. Basics/Demographics

1.6. Why isn't "common law relationship" included as an option along with "married" and "unmarried?" Lynette said that although many say that living together/long-term relationship is the same as marriage, the literature says that married/unmarried is the cut that actually determines risk.

2. Health History/Risks

2.2A. The item states, "Thinking back to just before you got pregnant with this baby, how did you feel about becoming pregnant?" It may be difficult for a woman to remember how she felt before she got pregnant. Suggest changing it or adding another item to get at how she feels now.

2.5-2.6. There's a huge difference between miscarriage at 6 weeks and stillbirth at 9 months. There's no way determine how the most recent previous pregnancy ended. Lynette said that the research team discussed the infant death item at great length and will review closely after testing.

8. Depression

8.4-8.13. How will we identify women with pre-existing mental health conditions, as there is no question on this? Question 8.4 asks for history.

Lynette said that the research team grappled with doing a full psych interview to get at depression, but the literature showed the Edinburgh is very well validated, so they incorporated it within the screener. Even so, it will still miss some depressed women. Several providers who had experience with the Edinburgh said it was a good tool, but that Native Americans and African Americans could not relate to the item: "Things have been getting on top of me." Therefore, they had to get permission from the author to re-word it.

Lynette said that women with even mild depression would get a package of interventions.

10. Abuse/Violence

10.4. This item asks about emotional abuse, but there are no Tier 2 questions. Given how common emotional abuse is during pregnancy, don't we need follow up questions here? Brenda said this is something we want to pick up on, and that we need to look at isolation as well.

12. Breastfeeding

Glad to see a breastfeeding question included – where did it come from? Lynette said that the literature says to assume all women will breastfeed and go from there, but the question is not stated that way - it's one of the very few questions included in the screener that was not previously validated. She agrees that the

question could be better, but a panel came up with it, and for now, they will see how it plays.

Risk factors that DWG members suggested adding to the screener:

1. Teen pregnancy. Since teenage pregnancy isn't a risk factor in and of itself, do we have any way to identify and serve teen moms? Lynette confirmed that young teens (age 14) may screen negative with this tool.
2. Cognitive delays. Mary noted that some women with cognitive delays have strong support and do well.
3. Chronic mental illness. Lynette said we may want to look at this next year.
4. Low education level. (NOTE: The screener does ask education level.)
5. Low reading level. Lynette said that the screener is at the 6th grade reading level, and interviewers will be asked to be on the lookout for women who read at a lower level and may not understand certain words.
6. Non-English speaking.

Lynette said that these points are well taken, but the tool is not perfect and never will be. The research team has struggled with what to include on the screener and can't make changes before the testing starts. The input received on the screener today will be considered after the field test, when the research team looks at what was learned. Doug said he is open to automatic eligibility with respect to factors such as age, developmental disabilities, etc.

Suggestion to add a "notes box" to give interviewers the option to code other issues. Lynette said this was in at one point, but it got pitched. However, other issues will be identified as the research team debriefs after the field test. Lynette noted that we don't have the resources to remove all barriers for all women, and that we're triaging to reach those at highest risk. In our population-based, outcomes-monitoring model, everyone gets something, and those at high risk, get more.

Interviewer qualifications. What qualifications do interviewers need? Lynette said that they envisioned that interviewers would be trained professionals and para-professionals. Nancy said that interviewers must be the kind of people who can quickly establish trust. Several others concurred that strong relationship-building skills are essential. Doug noted that Dr. Olds maintains that nurses are better accepted by clients than social workers are, and that nurses are more successful in engaging and maintaining clients.

Follow-up screening. Right now, Kent is only piloting the screener at WIC entry, but the plan is that MIHP will re-screen women periodically, as some will move from low to high risk and back again over time. It was suggested that re-screening be done at each trimester, at birth, and at the WIC postpartum checkup. After WIC entry, WIC doesn't screen again until postpartum, so any interim screening procedures would have to be worked out. Screenings will be closely coordinated with the woman's medical home – there will be a very strong link between the OB and the MIHP providers. It hasn't yet

been determined if the original interviewer will be conducting the follow-up screens with a given woman.

Role of consumers in development of screener. Consumers have not had a role in the development of the screener as yet, but they will during the reactivity portion of data collection. After each woman is screened during the field testing, she will be asked how she experienced the process, and how she reacted to specific questions (e.g., Did any of the questions make you feel uncomfortable? Were there things you just didn't tell us about because you didn't feel comfortable?). Paul said he keeps hearing that women fear prosecution for refusing to name their baby's father – is this relevant for the screener? Lynette said one of the reactivity questions asks, "Are you afraid that the way you answer any of these questions might lead to the loss of your child?" This doesn't address paternity per se, however. Women must sign a consent form to participate in the pilot survey. They receive a $15 gift card as a participation incentive.

Paul and Mary Pat said that programs risk failure if they don't include the consumer perspective. Paul suggested that conducting focus groups with WIC participants would decrease the pressure of having to answer as an individual. Doug said this was a great idea but would require funds.

Nancy and Darlene said that they've gotten feedback that women are more apt to answer honestly if they are given time to review the screener and consider the questions before the interview – "If you just come out and ask me if I drink, I'll say no, but if you give me the time to think about it first, or to do the screener myself, I'll be able to be more honest." Lynette said she would look into adding this reactivity question to the list: "Would you have answered the questions more honestly if you had done the screener by yourself, instead of being interviewed by another person?" Later, when the screener is available online, women will have the option of completing the screener themselves.

Comments on the screener. The screener will be posted on the MIHP web site. All MSS/ISS providers were notified that the draft screener is available for review. Additional comments on it should be emailed to Lynette. Lynette will bring up the DWG's comments, as well as those submitted by other stakeholders, to the research team for their consideration as they revise the screener after the pilot testing is completed. The next version will be different.

Stratification. Risk stratification will be discussed at a future meeting. Algorithms will be programmed to determine risk stratification, similar to the WIC risk code sheet.

MIHP Maternal Risks, Interventions, and Outcomes Matrix

Lynette explained that this is the most recent iteration of the *MIHP Maternal Risks, Interventions, and Outcomes Matrix*. DWG members have seen several previous versions. Brenda noted that this is the first time we've seen the starting point for defining the interventions, and that it's important for the DWG to provide input on best practices. The matrix will continue to evolve, and there will be many chances to comment on it.

The matrix identifies two, rather than three, risk levels. The difference between interventions for moderate risk and high risk was so minimal, that the research team put them together. Note that the phrase "coordinate with OB provider and health plan" appears throughout the document. The expectation is that MIHP providers will build relationships through direct phone contact, rather than just send letters. The bar is being raised with respect to coordination with the medical home. There also is a strong emphasis on linking to community services (e.g., family planning.) and continuing quality improvement.

Questions/comments were raised about the following risk factors on the matrix:

Risk Factor 1 – Inadequate Prenatal Care.
Where did the 20 weeks come from? If a woman waits that long to enter prenatal care, we've already lost a great deal of ground. Lynette noted the literature indicates that, contrary to popular belief, prenatal care is a very oversold thing. There's a major controversy on when prenatal care should begin. Many think it needn't start before 12 weeks (ACOG). Mark said physicians are concerned about early prenatal care because of liability issues. Brenda said there are many different standards (e.g., ACOG, HEDIS, etc.), even within the department. Peggy said the definition of prenatal care is important, not because of the medical care, but because of what comes with it. Darlene said that the sooner women enter prenatal care, the sooner other risks can be addressed. Also, everything is reported in trimesters, but 20 weeks cuts in between. We can certainly debate the 20 weeks, but eventually, MDCH is going to have to take a stand on this.

Other points:

- Once a woman calls for a prenatal care appointment, it takes time to get in to see a provider. Many women do everything they can to get into prenatal care, but are not successful.
- The matrix says that there is one session to cover importance of prenatal care, but this won't be enough for many women. Lynette replied that EVERYTHING in intervention column is the MINIMUM.
- The literature shows that prenatal vitamins are important at 3 weeks before the pregnancy, but taking vitamins during pregnancy does not change outcomes.
- Early entry into WIC (risk assessment, referrals, food) does impact LBW.
- Very few OBs are doing a good job with respect to dental care.

Risk Factor 2 – Smoking/Tobacco Use.
Women who smoke are at high risk for pre-term delivery and low birth weight. Lynette noted that the research team is recommending the 5 A Approach (ask, advise, assess, assist, arrange), described on the MDCH web site, because a big foundation project endorses it. It incorporates readiness to change. Birth outcome is improved if a woman quits just 3 days before birth. The patch is not

the only pharmacological option - welbutrin should be considered for woman who can't quit. We're not addressing second-hand smoke during pregnancy.

Health plans are required to provide smoking cessation services, but who will pay on the FFS side? Lynette said that this cost could be built into the case rates so that the MIHP could subcontract with a community agency that provides smoking cessation services. If no smoking cessation program is available in the geographic area, the MIHP would have to provide it directly and this cost could be built into the case rate. This means that MDCH would have to provide smoking cessation training for providers. Doug said this is a good point, and it will have to be addressed somehow.

Risk Factor 5 – Depression/Behavioral Health.
This risk factor should be titled "Depression", rather than "Depression/Behavioral Health." MIHP staff will not be expected to do mental health treatment. Moderately/ severely depressed women will be referred to CMH. MIHP staff will coordinate mental health referrals with the CMH, OB, and health plan. Mary said that these same partners should conjointly develop emergency/crisis plans for women who are severely depressed. She noted that 40% of adolescents with severe emotional disturbance become pregnant, and interventions may need to be adapted for different sub-populations. She also suggested that we will need to educate the mental health community on what screening tools we're using, etc.

Stress is not included as a prenatal risk factor (domain of care). Carolyn said she didn't see any interventions on the matrix related to stress, which is a huge issue. Lynette said that the literature on the effect of stress on pre-term labor is very mixed. The current thinking is that stress is a marker of some other factor that effects pre-term labor. The IHCS research team thought that perhaps high stress is a factor (like cognitive impairment) that would bump up a woman's risk level, but it's very difficult to assess stress by self-report – the literature suggests that we would have to measure cortisol levels. Dr. Claudia Holzman at MSU has a huge database of women covered by Medicaid, including cortisol levels. This likely represents a future research opportunity.

It was suggested that the literature is showing the effects of stress on African American immigrants in the next generation. Lynette said there is a big trend now contradicting this – that it's not stress per se, but that stress is a marker of racism. We could teach stress management as an intervention, but it won't change birth outcomes, so do we really want to spend resources on it? Carolyn noted that we'd be decreasing stress through other interventions, such as meeting basic needs. Lynette said stress is clearly a thread throughout all cases – we need to attend to it, even if that means we simply acknowledge it. Doug said we intend to keep tuned into the literature on this.

Reimbursement

Pat said that providers are on the edge of their seats, waiting to know about the new reimbursement policy. When will we hear about this? It's unlikely that we will have it

by October 1. Sue said that reimbursement is a concern of private providers, and cautioned we don't rush on this, because it's too important. She said that when managed care came in, providers panicked and shut their doors – we should be clear with everyone that this will be a slow process.

Doug said that the case rate will be variable, based on risk-level, outcomes and other factors. Workers are looking at case rates now and doing some population estimates. Medicaid actuaries will begin looking at the numbers soon. We can't determine how we'll incentivize providers until we figure out the stratification piece. Jackie said that MDCH will present the methodology of the case rate to the DWG for its review.

Illinois WIC/Family Case Management Programs. Stacey, Suzette and Lynette talked with Illinois for an hour yesterday about their Medicaid Family Case Management program, which is closely tied to WIC. 97% of the women in their case management program enter through WIC; the women don't even differentiate between the two programs. The Illinois infant mortality rate has gone from 11 to 7 per 1000, which they attribute to co-locating case management and WIC. 122 agencies, many of which are private, provide the case management. They are reimbursed on a case rate basis. The Illinois case management program is more traditional than what we are proposing for MIHP.

Providing Input on Matrix

Brenda said that the matrix is an impressive work and that it's a live document. We don't have time to review the entire thing today, so DWG members are asked to send any additional feedback on it to Lynette. Sheila suggested that it would help if comments included recommendations and supportive documentation. Brenda seconded this, noting that providing data or anecdotal observations (if occurrence is frequent) to back up our suggestions would be very much appreciated.

DWG Notes

Brenda asked if Deb should continue to produce detailed notes on DWG meetings as she has been doing, or are the notes too lengthy for DWG members and other stakeholders to read? Mark said some of us represent numerous constituencies that can't be here and the detailed notes are useful to keep people current. The consensus was to continue with the detailed notes.

April 2005 Trainings on the MIHP Design Project for MSS/ISS Providers

Full-day MSS/ISS trainings on the MIHP Design Project are scheduled as follows:

Detroit	April 22
Grand Rapids	April 26
Saginaw	April 28
Traverse City	April 29

Through these trainings, MDCH wants to ensure that every MSS/ISS provider has an opportunity to hear about how the design is moving along, and to review and discuss the initial data, goals, design criteria, etc. By the training dates, we will have an even clearer idea of what all we intend to roll out on Oct. 1 (e.g., screening tool, matrix, contract language, etc.), knowing that we will weave in other changes as we go along. Brenda said, "MDCH must be committed to serving the people, but can only do this through the providers. Our intent is to give every provider the opportunity, training, and support they need to make the necessary changes. Although some may decide they don't want to make these changes, it is not our intent to lose providers."

Traditionally, the spring MSS/ISS trainings have been targeted toward MSS/ISS coordinators and team members, but this time, health officers, CEOs, finance officers, etc. are also invited. Due to space and cost limitations, each agency will be limited to sending a total of 4 persons. The training dates will be publicized soon.

Other training (e.g., on the screening tool) will need to take place over the summer, and MDCH is figuring out how to fund this. In-depth training on the new rate structure also will be provided for MSS/ISS providers.

MIHP Staffing Pattern

Pat said that providers need to know about MIHP staffing now. As staff leave or retire over the next 6 months, whom should we hire? Do we replace nurses, social workers, dieticians? Will multi-disciplinary teams be required? Pros? Parapros? Lynette and Brenda said that the new focus will be on outcomes, rather than who does the work, so the MIHP will be less rigid about staffing. Staff can be used to best fit the program needs. We can presume nurses will be needed, dieticians will be needed (unless there are lots of WIC clinics in the area), social workers become an option, CHWs (parapros) become an option for outreach, lactation consultants become an option, etc. Mary suggested that the interventions that are selected would drive staffing.

Pat said that MSS/ISS had staffing guidelines that specified what credentials were required for each discipline. The guidelines were sometimes hard to meet, but they were quality standards, and she'd hate to see them get thrown out. Brenda said we've only had preliminary discussions on staffing and haven't concluded that we'll get rid of staffing standards, and that perhaps we can discuss this further at our next meeting.

Next DWG Meeting

Doug Paterson thanked everyone for their participation and noted that our next meeting is March 17 here at the MPHI Interactive Learning Center. (NOTE: The March 17 meeting has since been canceled.)

Running List of Systems Issues

1. Physicians won't see women until they're in their second trimester.

2. HEDIS says that a postpartum visit must occur on or between 21 days and 56 days after delivery, but many women go earlier, so the visit doesn't count.
3. Service capacity is limited (e.g., substance abuse treatment). (Do we have effective treatment models? How available are they? If the service were reimbursable under the MIHP, would it create more capacity?)
4. Many women refuse services because they fear the system will remove their children.
5. Many high-risk women are transient and hard to enroll in Medicaid, so we can't serve them - loss of the Medicaid outreach funds makes it worse. (Is this something for prenatal initiative to address?)
6. An MSS program had a CMH employee as the social worker on its team. CMH wouldn't allow her to serve MSS clients because the MSS MA rate was less than the CMH MA rate.
7. *The Paternity Act. MCLA, 722.712. Child born out of wedlock; liability of parents for expenses*. Section 2 (2). If Medicaid has paid the confinement and pregnancy expenses of a mother…based on the father's ability to pay and any other relevant factors, the court may apportion not more than 100% of the reasonable and necessary confinement and pregnancy costs to the father…(4) The court order shall provide that if the father marries the mother after the birth of the child and provides documentation of the marriage to the friend of the court, the father's obligation for payment of any remaining unpaid confinement expenses is abated subject to reinstatement after notice and hearing for good cause shown, including, but not limited to, dissolution of the marriage.
8. Some policies and programs limit our ability to engage women to participate. For example, women can't get released from the FIA work requirement when they're 9 months pregnant.